STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 01 B. WING	11/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/09/11 Facility Number: 000250 Provider Number: 155359 AIM Number: 100289980 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Riverbend Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 66 and had a census of 43 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/15/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 medical records storage rooms with combustibles, measuring over	K0029	K 029 SS=E Fire Rating1. The corridor door to Medical Records storage room now has a self closing device installed.2. Maintenance Director educated on Fire Rating of doors. Audit was completed on all corridor	12/09/2011

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	50 square feet in size, was provided with a self closing device. This deficient practice could affect all resident evacuated through the front corridor in the event of an emergency. Findings include: Based on observation with the Maintenance Supervisor on 11/09/11 at 1:05 p.m., the corridor door to the medical records storage room lacked a self closing device. The storage room measured over 50 square feet in size and was being used for storage of cardboard boxes and medical records. This was confirmed by the Maintenance Supervisor at the time of observation. 3.1-19(b)		doors for necessary self closing doors. All doors meet fire rating standard.3. Maintenance Director will do audits five times weekly x 2 weeks. Then one time weekly for 4 weeks x 3 months.4. Results of these checks will be forwarded to the facility Risk Management Quality Improvement Committee for further review and recommendations, until 100% compliance is achevied times 3 months.	
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 6 of 6 exits were readily	K0038	K 038 SS=E Exit access accessible1. Codes have been placed on all exit doors.2. No other areas affected3. Maintenance Director educated on posting of codes on doors.	12/09/2011

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	accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice affects 4 or 5 residents out of 43 residents with no medical diagnoses requiring security measures. Findings include: Based on observation on with the Maintenance Supervisor on 11/09/11 from 12:10 p.m. to 2:10 p.m., all exit doors were magnetically locked and could be opened by entering a code, but the code was not posted. Based		Maintenance Director will do audits five times weekly x 2 weeks. Then one time weekly for 4 weeks x 3 months.4. Results of these checks will be forwarded to the facility Risk Management Quality Improvement Committee for further review and recommendations, until 100% compliance is achevied times 3 months.	

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	on interview with the Maintenance Supervisor and the Administrator at 2:00 p.m., not all residents have a clinical diagnosis to be in a secure building. The Administrator stated four or five residents were not diagnosed with a clinical diagnosis requiring specialized security measures. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA	K0144	K 144 SS=F Generator inspection1. Contractor contacted on 11-18-2011 to install a remote manual switch. Letter enclosed with Plan of Correction.2. No other areas affected3. Staff educated on use and location of manual switch. Maintenance Director will do audits five times weekly x 2 weeks. Then one time weekly for 4 weeks x 3 months for proper functioning.4. Results of these checks will be forwarded to the facility Risk Management Quality Improvement Committee for further review and recommendations, until 100% compliance is achevied times 3 months.	12/09/2011

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	37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Supervisor on 11/09/11 during a tour of the facility from 12:10 a.m. to 2:10 p.m., the facility did not have a remote manual stop for the emergency generator. Based on an interview with the Maintenance Supervisor at 1:18 p.m., the generator had a motor rated over 100 horsepower. 3-1.19(b)			